DEPARTMENT FOR MEDICAID SERVICES
HOME AND COMMUNITY BASED WAIVER SERVICES MANUAL

Cabinet for Health Services
Department for Medicaid Services
Division of Long Term Care
275 East Main Street 6W-B
Frankfort, KY 40621

CABINET FOR HEALTH SERVICES
DEPARTMENT FOR MEDICAID SERVICES

HOME AND COMMUNITY BASED MANUAL

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SECTION I

INTRODUCTION

SECTION I - INTRODUCTION

I. INTRODUCTION

A. Introduction

The Kentucky Medicaid Program Home and Community Based (HCB) Waiver Services Manual provides Medicaid providers with a tool to be used when providing services to qualified Medicaid members.

This manual shall provide basic information concerning coverage policy. It shall assist providers in understanding what procedures are reimbursable. Precise adherence to policy shall be imperative.

B. Fiscal Agent

The Department for Medicaid Services contracts with a fiscal agent for the operation of the Kentucky Medicaid Management Information System (MMIS). The fiscal agent receives and processes all claims for medical services provided to Kentucky Medicaid members.

C. General Information

The Department for Medicaid Services shall be bound by both Federal and State statutes and regulations governing the administration of the State Plan. The state shall not be reimbursed by the federal government for monies improperly paid to providers for non-covered, unallowable medical services. Therefore, Kentucky Medicaid may request a return of any monies improperly paid to providers for non-covered services.

The Kentucky Medicaid Program serves eligible members of all ages. Kentucky Medicaid coverage and limitations of covered health care services specific to the Home and Community Based Waiver Program shall be specified in the body of this manual in Sections IV, V, VI.

SECTION II

COMMONWEALTH OF KENTUCKY MEDICAID PROGRAM

SECTION II – COMMONWEALTH OF KENTUCKY MEDICAID PROGRAM

II. COMMONWEALTH OF KENTUCKY MEDICAID PROGRAM

A. Policy

The basic objective of the Kentucky Medicaid Program shall be to ensure the availability and accessibility of quality medical care to eligible program members.

The Medicaid Program shall be the payor of last resort. If the member has an insurance policy, veteran's coverage, or other third party coverage of medical expenses, that party shall be primarily liable for the member's medical expenses. Accordingly, the provider of service shall seek reimbursement from the third party groups for medical services provided prior to billing Medicaid. If a provider receives payment from a member, payment shall not be made by Medicaid. If a payment is made by a third party, Medicaid shall not be responsible for any further payment above the Medicaid maximum allowable payment.

In addition to statutory and regulatory provisions, several specific policies have been established through the assistance of professional advisory committees. Principally, some of these policies are as follows:

All participating providers shall agree to provide medical treatment according to standard medical practice accepted by their professional organization and to provide Medicaid-covered services in compliance with federal and state statutes regardless of age, color, creed, disability, ethnicity, gender, marital status, national origin, race, religion, or sexual orientation.

Providers shall comply with the Americans with Disabilities Act and any amendments, rules and regulations of this act.

Each eligible medical professional shall be given the choice of whether or not to participate in the Kentucky Medicaid Program in accordance with 907 KAR 1:672. From those professionals who

have chosen to participate, members may select the provider from whom they choose to receive their medical care.

If the Department makes payment for a covered service and the provider accepts this payment in accordance with the Department's fee structure, the amounts paid shall be considered payment in full; a bill for the same service shall not be tendered to the member, and a payment for the same service shall not be accepted from the member. The provider may bill the member for services not covered by Kentucky Medicaid.

Providers of medical service or authorized representatives attest by their signatures, that the presented claims are valid and in good faith. Fraudulent claims shall be punishable by fine, imprisonment or both. Facsimiles, stamped or computer generated signatures shall not be acceptable.

The member's Kentucky Medical Assistance Identification Card should be carefully checked to see that the member's name appears on the card and that the card is valid for the period of time in which the services are to be rendered. If there is any doubt about the identity of the member, you may request a second form of identification. A provider can not be paid for services rendered to an ineligible person. Failure to validate the identity of a Medicaid member prior to a service being rendered may result in being out of compliance with KAR 1:671. Any claims paid by the Department for Medicaid Services on behalf of an ineligible person may be recouped from the provider.

The provider's adherence to the application of policies in this manual shall be monitored through either on-site audits, postpayment review of claims by the Department, computer audits or edits of claims. When computer audits or edits fail to function properly, the application of policies in this manual shall remain in effect. Therefore, claims shall be subject to postpayment review by the Department.

All providers shall be subject to rules, laws, and regulations issued by appropriate levels of federal and state legislative, judiciary and administrative branches.

All services provided to Medicaid members shall be on a level of care that is equal to that extended private pay individuals or others, and on a level normally expected of a person serving the public in a professional capacity.

All members shall be entitled to the same level of confidentiality afforded persons NOT eligible for Medicaid benefits.

Claims shall not be allowed for services outside the scope of allowable benefits within a particular program specialty. Likewise, claims shall not be paid for services that required and were not granted prior authorization by the Kentucky Medicaid Program. In addition, providers are subject to provisions in 907 KAR 1:671, 907 KAR 1:672, and 907 KAR 1:673.

Claims shall not be paid for medically unnecessary items, services, or supplies. The member may be billed for non-covered items and services. Providers shall notify members in advance of their liability for the charges for non-medically necessary and non-covered services.

If a member makes payment for a covered service, and that payment is accepted by the provider as either partial payment or payment in full for that service, responsibility for reimbursement shall not be attached to the Department and a bill for the same service shall not be paid by the Department. However, a member with spenddown coverage may be responsible for a portion of the medical expenses they have incurred.

B. Appeal Process for Refund Requests

Inappropriate overpayments to providers that are identified in the postpayment review of claims shall result in a refund request.

If a refund request occurs subsequent to a postpayment review by the Department for Medicaid Services or its agent, the provider may submit a refund to the Kentucky State Treasurer or appeal the Medicaid request for refund in writing by providing clarification and documentation that may alter the agency findings. This information relating to clarification shall be sent to :

DIVISION OF LONG TERM CARE
DEPARTMENT FOR MEDICAID SERVICES
CABINET FOR HEALTH SERVICES
275 EAST MAIN STREET
FRANKFORT KY 40621

If no response (refund or appeal) has been filed with Medicaid by the provider within thirty (30) days of the refund request, assent to the findings shall be assumed. If a refund check or request for a payment plan is not received within sixty (60) days, Medicaid shall deduct the refund amount from future payments.

C. Timely Submission of Claims

According to federal regulations, claims shall be billed to Medicaid within twelve (12) months of the date of service or six (6) months from the adjudication date of the Medicare payment date or other insurance. Federal regulations define “Timely submission of claims” as received by Medicaid “no later than twelve (12) months from the date of service.” Received is defined in 42 CFR 447.45(d)(5) as follows, “The date of receipt is the date the agency receives the claim, as indicated by its date stamp on the claim.” To consider those claims twelve (12) months past the service date for processing, the provider shall attach documentation showing **RECEIPT** by Medicaid, the fiscal agent and documentation showing subsequent billing efforts. Claim copies alone shall not be acceptable documentation of timely billing. Claims shall not be considered for payment if more than twelve (12) months have elapsed between **EACH RECEIPT** of the aged claim by the program.

Claims should be submitted to:

Unisys Corporation
P.O. Box 2100
Provider Services
Frankfort, KY 40602-2100
1-877-838-5085 – Provider Enrollment
1-800-807-1232 – Provider Assistance

D. Kentucky Patient Access and Care System (KenPAC)

KenPAC is a statewide patient care system which provides Medicaid members with a primary care provider. The primary care provider shall be responsible for providing or arranging for the member's primary care and for referral of other medical services. KenPAC members shall be identified by a green Medical Assistance Identification (MAID) card.

Medicaid members receiving waiver services, as well as nursing facility and Long Term Care services, are exempt from participation in KenPAC.

E. Lock-In Program

The Department shall monitor and review utilization patterns of Medicaid members to ensure that benefits received are at an appropriate frequency and are medically necessary given the condition presented by the member. The Department shall investigate all complaints concerning members who are believed to be over-utilizing the Medicaid Program.

The Department shall assign one (1) physician to serve as a case manager and one (1) pharmacy. The member shall be required to utilize only the services of these providers, except in cases of emergency services and appropriate referrals by the case manager. In addition, provider and members shall comply with the provisions set forth in 907 KAR 1:677, Medicaid Member Lock-In.

Providers who are not designated as lock-in case managers or pharmacies shall not receive payment for services provided to a member assigned to the lock-in program, unless the case manager has pre-approved a referral or for emergency services. Members assigned to the lock-in program shall have a pink MAID card and the name of the case manager and pharmacy shall appear on the face of the card.

F. Early and Periodic Screening, Diagnosis and Treatment (EPSDT) Program

Under the EPSDT program, Medicaid eligible children, from birth through the end of the child's birth month of his twenty-first (21) year, may receive preventative, diagnostic and treatment services by participating providers. The goal of the program is to provide quality preventative health care by performing prescribed screenings at specified time intervals according to age (termed a periodicity schedule) to identify potential physical and mental health problems. These screenings shall include a history and physical examination, developmental assessment, laboratory tests, immunizations, health education and other tests or procedures medically necessary to determine potential problems. Another goal of the program is to reimburse for medically necessary services and treatments, even if the service or treatment is not normally covered by Kentucky Medicaid. However, the service or treatment must be listed in 42 USC Section 1396_d(a) which defines what services can be covered by state Medicaid programs. More information regarding the EPSDT program can be obtained by calling the EPSDT program within the Department for Medicaid Services.

G. Kentucky Health Care Partnership Program

In accordance with 907 KAR 1:705, the Department shall implement, within the Medicaid Program, a capitation managed care system for physical health service for persons residing in Region 3 (Shelby, Spencer, Trimble, Wayne, Marion, Meade,

Nelson, Oldham, Hardin, Henry, Jefferson, LaRue, Breckinridge, Bullitt, Carroll, and Grayson counties).

Medicaid members receiving waiver services, as well as nursing facility and Long Term Care services, are exempt from participation in a capitation managed care system. These members receive services through the traditional Medicaid program.

H. EMPOWER Kentucky Transportation Initiative

In accordance with 907 KAR 3:065, the Department shall implement, within the Medicaid Program, as an EMPOWER Kentucky Initiative, a capitation non-emergency medical transportation delivery system excluding ambulatory stretcher services. The Department has entered into a contract with the Transportation Cabinet, along with three other Cabinets, to implement this program incrementally statewide beginning in June 1998. This new system is designed to extend service to areas of the state currently under-served, provide transportation alternatives to more people, encourage efficiency and discourage fraud and abuse.

SECTION III

OVERVIEW OF HOME AND COMMUNITY BASED WAIVER PROGRAM

SECTION III – OVERVIEW OF HOME AND COMMUNITY BASED WAIVER PROGRAM

III. OVERVIEW OF HOME AND COMMUNITY BASED WAIVER PROGRAM

A. Waiver Requested

The Department for Medicaid Services (DMS) requested that the Secretary of the United States Department of Health and Human Services (HHS) exercise his authority under Section 1915 (c) of the Social Security Act to grant a waiver of certain federal requirements that would permit Medicaid coverage under the State Plan for a broad array of home and community based services that may be required by the Medicaid member who would otherwise require the Nursing Facility (NF) level of care. The array of services available under the Home and Community Based (HCB) Waiver include:

1. Assessment
2. Reassessment
3. Case Management
4. Homemaker Services
5. Personal Care Services
6. Respite Care Services
7. Minor Home Adaptations
8. Attendant Care Services
9. Adult Day Health Care Services

B. Individual's Freedom of Choice

An individual eligible to receive HCB waiver services shall be given a choice to:

1. Receive home and community based services or nursing facility services; and
2. Select participating HCB (including Adult Day Health Care providers) waiver providers from whom he wishes to receive services.

The MAP-350 form is utilized to document choice was given to the individual. An HCB Waiver provider shall require the member to

sign a MAP-350 form at the time of application or reapplication and each recertification.

C. Target Population and General Financial and Waiver Eligibility Requirements

The target groups for HCB services are persons who are aged or disabled and who may, without these services, be admitted to a nursing facility for which the cost may be reimbursed under the existing State Plan. Persons who meet the financial eligibility and the nursing facility level of care criteria may receive waiver services.

The eligibility groups include the mandatory categorically needy and optional categorically needy. This shall include the aged, blind and disabled individuals and persons determined eligible under the Aid to Families with Dependent Children (AFDC) category and AFDC related categories.

1. Medicaid Eligibility Process (DCBS)

(a) The DMS shall notify the individual, the HCB Waiver provider and the Department for Community Based Services (DCBS) when the individual has been determined appropriate for HCB Waiver services, the effective date and the monthly cost of the requested services.

(b) The individual and family or responsible party shall be advised to make application for eligibility at the DCBS office in the county where the individual lives in order to ensure Medicaid coverage for services. At the time of application, the applicant (spouse or interested party representing the HCB member) should bring proof of the members' social security number, income (unearned or earned), resources, life insurance policies, burial contracts, health insurance, and medical bills.

(c) The DCBS is required to complete an assessment of the countable resources of the individual and the non-HCB Waiver spouse. The assessment includes a comparison of the combined countable resources to the current Medicaid resource allowance for the HCB Waiver member and the non-HCB Waiver spouse to determine if the HCB Waiver member meets resource eligibility for Medicaid.

(d) Resources are defined as cash money and any other personal property or real property that an individual or couple owns; has the right, authority, or power to convert to cash; and is not legally restricted from using for support and maintenance. Resources may include, but are not limited to, checking and savings accounts, stocks or bonds, certificates of deposit, automobiles, land, buildings, burial reserves, and life insurance policies.

(e) Certain types of resources are excluded and are not considered in the Medicaid eligibility determination. These resources include homestead property and adjoining land, household goods and personal effects, a burial arrangement, one automobile used for employment, to obtain medical treatment or by the community spouse, burial spaces and plots, life estate interests, IRA, KEOGHS, and retirement funds which meet the Internal Revenue guidelines for tax deferment.

(f) The resources of an individual requesting or receiving services through the HCB Waiver must be within Medicaid Program guidelines. The resources of the HCB Waiver member's spouse are considered.

(g) Income is defined as money received from statutory benefits (Social Security, VA pension, Black Lung

benefits, Railroad Retirement benefit), pension plans, rental property, investments or wages for labor or services. Income may be unearned or earned. The income of the individual requesting or receiving services through the HCB Waiver must be within Medicaid Program guidelines. Only the income of the HCB Waiver member is considered. The special income limit is equal to 300% of the SSI standard.

(h) The institutional deeming rules shall be applied to the HCB Waiver member. Waiver members shall be allowed to retain from their own income for their basic maintenance needs an amount equal to the Supplemental Social Security Income (SSI) basic benefit rate plus the SSI general disregard. This allowable maintenance amount shall change if the SSI benefit rate or standard deduction changes. The patient liability for the month of admission to the waiver, however, would usually be zero with the following exceptions:

(1) Community deeming rules for Medicaid eligibility shall be used for the month of admission for all HCB Waiver members who are either married or under the age of eighteen (18). This means that the income and resources of the spouse or parent shall be considered to be available for the months of admission only. For the second month and each succeeding month of HCB participation, only the income and resources of the HCB member shall be used to determine Medicaid eligibility.

(2) The member has been discharged from a nursing facility, ICF/MR/DD facility, hospice program, or another Home and Community

Based Waiver program, within thirty (30) days of the effective date for HCB Waiver services.

(i) The individual should indicate to the DCBS that they are applying for eligibility under the special income category of the HCB Waiver.

(j) The member and family or responsible party shall be advised of the importance of contacting the local DCBS office in the following situation:

(1) The member's Medicaid eligibility was based upon a recent nursing facility admission.

(2) The member's Medicaid eligibility was based upon the "Spend-Down" category of eligibility.

(3) The member's Medicaid eligibility was based upon SSI eligibility.

(4) Whenever there is a change in the member's circumstance.

2. Member's Continuing Income Liability

If it is determined by the local DCBS office that a member has a continuing income liability, this amount shall be paid to the HCB provider by the member or responsible party and shall be deducted monthly from the Title XIX HCB payments to the provider. Notification of the amount of the continuing income shall be forwarded to the HCB provider from Medicaid Services on Form MAP-552. It is the responsibility of the provider to collect this money from the member.

If Adult Day Health Care (ADHC) is one of the HCB Waiver Program services, the ADHC provider shall be responsible for collecting the amount of the available income and not the HCB Waiver provider. The amount of the available income

shall be deducted from the ADHC's Medicaid Program payment.

The HCB provider shall continue to bill all covered HCB services received by the member to Medicaid directly except for Adult Day Health Care which shall be billed by the ADHC provider.

NOTE: **The provider may not collect more than the actual amount of the service provided during the month by the agency.**

3. Waiver Eligibility Determination

(a) An individual may be referred for HCB Waiver services by the individual requesting HCB waiver services, individual's legal representative or the individual's attending physician, Physician Assistant (PA) or Advanced Registered Nurse Practitioner (ARNP).

(b) To be eligible for participation in the HCB Waiver program members shall meet the level of care criteria for nursing facility services in accordance with 907 KAR 1:022. The members attending physician, shall recommend HCB waiver services and certify that without waiver services the member would be admitted by a physician's order to a nursing facility.

(c) The Peer Review Organization (PRO) shall perform a level of care determination for all members who wish to be considered for participation in the HCB waiver program. The level of care determination shall be made at least every twelve (12) months.

The HCB Waiver provider shall telephone the PRO to provide the information necessary to perform the level of care determination. The level of care certification

form shall be completed by the PRO based upon the information provided to them over the telephone. It is very important that the individual contacting PRO be knowledgeable about the member's condition and able to answer questions. The form shall be forwarded by the PRO to the HCB waiver provider.

(d) The HCB Waiver provider, individual member, and DCBS shall receive notification from the PRO of the denial for nursing facility level of care. If the individual/member or his legal representative disagrees with the adverse determination, the member shall have the right to an appeal in accordance with 907 KAR 1:563.

(e) For acute care hospital inpatients whose care needs indicate that nursing facility services may be required, hospital discharge planers are requested to refer the individual to an HCB Waiver provider of their choice.

(f) It shall be the Nursing Facility's responsibility to ensure that all members are informed of the availability of HCB Waiver services as an alternative prior to admission to the nursing facility and annually thereafter.

(g) HCB Waiver services shall not be provided to an individual who is an inpatient of a hospital, nursing facility, intermediate care facility for individuals with mental retardation or developmental disabilities (ICF/MR/DD) or enrolled in a Medicaid covered Hospice program. An individual who is a resident of a licensed personal care home or who is receiving a service in another Medicaid home and community based services waiver program shall not be eligible to receive HCB Waiver services.

(h) An HCB Waiver provider shall notify the local DCBS Office and the PRO on a MAP-24 form if a member is terminated from the HCB Waiver program, or if the member is admitted for less than sixty (60) consecutive days to a nursing facility and is returning to the HCB Waiver program. An HCB member who remains in a nursing facility longer than sixty (60) consecutive days shall be terminated from HCB Waiver program. If the member requests readmission to the HCB Waiver program after sixty (60) consecutive days all procedures for a new admission shall be followed.

(i) The Department may exclude an individual for whom the aggregate cost of HCB Waiver services would reasonably be expected to exceed the cost of nursing facility services.

SECTION IV

CONDITIONS OF PARTICIPATION

IV. CONDITIONS OF PARTICIPATION

A. Participation Overview

To participate in the HCB Waiver Program, a provider shall meet the licensure requirements in accordance with 902 KAR 20:081 and be Medicare and Medicaid certified.

An agency desiring to participate as an HCB Waiver Provider must submit a completed enrollment packet and verification of their license to:

Provider Enrollment
Unisys Corporation
P.O. Box 2110
Frankfort, Kentucky 40602

Services shall be furnished by the participating HCB Waiver Provider or by others under contractual arrangement with the HCB Waiver Provider. Members shall not be enrolled for services which the agency cannot provide. Arrangements made by an HCB Waiver provider with other agencies to provide services shall be in writing and shall stipulate that receipt of payment by the HCB Waiver Provider for the service (whether in its own right or as an agent) discharges the liability of the member or the Medicaid Program to make any additional payment for service.

B. Provider Freedom of Choice

The freedom of choice concept has always been a fundamental principle governing the Kentucky Medicaid Program. Providers shall have the freedom to decide whether or not to accept eligible Medicaid members and to bill the Program for the medical care provided.

C. Overview of Record Requirements

The HCB Waiver provider shall retain fiscal reports, service and clinical records and incident reports regarding services provided for a period of at least five (5) years from the date that a covered service is provided, except in the case of a minor child, whose records shall be retained for three (3) years after the member reaches age of majority under state law, whichever is longest.

1. Clinical Records

The HCB Waiver provider shall be required to maintain for each member a clinical record which covers the services provided both directly and those provided through arrangements with other agencies.

The HCB Waiver clinical record shall contain:

(a) Pertinent current and past medical, nursing and social history;

(b) A current and complete MAP-351A form including the comprehensive assessment;

(c) A current and complete MAP109-HCBW form which shall include the member's current plan of care and request for prior authorization of HCB Waiver services;

(d) Copies of past and current MAP-350's signed by the member or legal representative;

(e) The name of the case manger;

(f) Documentation of each contact with, or on behalf of, an HCB member; and

(g) Documentation of each service provided which shall include:

(1) The date the service was provided;

(2) The duration of the service;

(3) The arrival and departure time of the provider of services, excluding travel time;

(4) Description of service(s) provided;

(5) Progress notes which shall evaluate the HCB Waiver member's needs through documentation of changes, responses and treatments; and

(6) The title and signature of the service provider.

2. Personnel Records

The HCB Waiver provider shall be required to retain a confidential personnel record for each staff person. Personnel records at minimum should include a copy of current license, if applicable, and documents as specified in 902 KAR 20:080 Section 4. Documentation shall be maintained in each personnel file that the staff member is free of communicable disease. If the employee contracts a communicable disease, they shall not be permitted to provide a service to a member until the condition is determined not to be contagious. The personnel file may be subject to review by the department.

3. Records Accessibility

The HCB Provider shall make information regarding service and financial records available to:

(a) The Department for Medicaid Services, or its designee;

(b) The Commonwealth of Kentucky, Cabinet for Health Services, Office of Inspector General, or its designee;

(c) The United States Department for Health and Human Services, or its designee;

(d) The United States General Accounting Office, or its designee;

(e) The Commonwealth of Kentucky, Office of the Auditor of Public Accounts, or its designee; and

(f) The Commonwealth of Kentucky, Office of the Attorney General, or its designee.

D. Provider Requirements

HCB Waiver Providers shall maintain a policy and procedures manual outlining policies which includes agency hours of operation, emergency contact, contingency plan(s) for emergencies and to accommodate back-up when usual care is unavailable, agency fee schedule and other pertinent agency operational information. HCB Waiver Providers shall ensure availability of their manual to agency staff, HCB members, family members or any other interested parties. Agency policy and procedure manuals may be subject to review by the Department.

HCB Waiver Providers shall be responsible for implementing a procedure which ensures the reporting of all incidences. Incidences may include, but are not limited to, the following:

1. Abuse, neglect, or exploitation of a member;

2. A slip or fall, medication error, or medical complication; or

3. Incidents caused by the member such as verbal and/or physical abuse of staff or other members, destruction or damage of property, and member self abuse.

HCB Waiver Providers shall ensure agency staff are trained in the prevention, identification, and reporting of abuse, neglect and exploitation. Cases of suspected abuse, neglect or exploitation shall be immediately reported to DCBS Adult Protective Services. The state hotline number for reporting suspected abuse, neglect or exploitation is 1-800-752-6200. HCB Waiver Providers shall ensure agency staff document each contact with DCBS, Adult Protective Services. This documentation, at a minimum, shall include date of contact, name of member the report is being made on behalf of, brief synopsis of allegations, name of the DCBS employee taking the report.

1. HCB Waiver Providers shall develop a process for reporting all incidents. This process shall include the development of a standardized form and instructions to be utilized by agency staff members when reporting an incident. The central file shall contain all of the HCB Waiver Provider's incident reports in chronological order in a binder for a period of one (1) year and be subject to review by the department. After which time, the incident reports shall be kept readily available for review in an accessible storage area for five (5) years.

2. HCB Waiver Providers shall implement a process for communicating the incident, the outcome and the prevention plan to:

   (a) An HCB member, family member or legal representative; and

   (b) The attending physician, PA or ARNP.

   This communication shall be documented and:

   (a) Recorded in the HCB member's case record; and

   (b) Signed and dated by the staff member making the entry.

3. HCB Waiver Providers shall be responsible for implementing a procedure which ensures the reporting of a complaint against an agency or its personnel by a member or interested party. HCB Waiver Providers shall make available to agency staff, members or interested parties the Office of Inspector General Hotline number which is 1-800-635-6290.

SECTION V

HOME AND COMMUNITY BASED WAIVER PROGRAM
COVERED SERVICES

SECTION V – HOME AND COMMUNITY BASED WAIVER PROGRAM COVERED SERVICES

V. HOME AND COMMUNITY BASED WAIVER PROGRAM COVERED SERVICES

An HCB covered waiver service shall be prior authorized (PA) by the Peer Review Organization (PRO) to ensure that the service or modification is adequate in relation to the HCB member's needs. Services provided without a PA letter are subject to non-payment. Coverage shall not continue for members who have not received services on a regular basis as ordered during the previous certification period. A covered service shall be provided in accordance with the member's approved plan of care. A member of the HCB member's family shall **not** provide the service.

A. Assessment Service

1. HCB assessment services shall include a comprehensive assessment which shall:

   (a) Identify the HCB member's needs and the services that an HCB member or family cannot manage or arrange;

   (b) Evaluate the HCB member's physical health, mental health, social supports, and environment;

   (c) Be requested by an individual requesting HCB waiver services, a family or legal representative of the individual, the individual's physician, a Physician's Assistant, or an ARNP;

   (d) Be conducted, within seven (7) calendar days of receipt of the request for assessment, by an assessment team comprised of two Registered Nurses (RN) or an RN and a qualified social worker, certified psychologist with autonomous functioning, licensed psychological practitioner, licensed marriage and family therapist or licensed professional clinical

counselor. The social worker shall be qualified on the basis of the HCB Waiver Provider's determination using the criteria specified in 907 KAR 1:160. At a minimum, the social worker shall have a bachelor's degree in social work, sociology or a related field.

(e) Include at least one (1) face-to-face contact with the HCB member and, if appropriate, the family. This contact shall be conducted by the RN or qualified social worker in the individual's home. The contact may begin in the hospital, nursing facility, the member's home or another place of residence at the time but shall be completed in a home visit. Person(s) (other than the RN and qualified social worker) may assist in gathering the information for the assessment process when the HCB Waiver Provider has determined that the person(s) is capable of performing this task.

(f) HCB Waiver packets received more than sixty (60) calendar days after the date of the assessment shall be returned unreviewed and a new assessment shall be completed.

The HCB assessment service shall be billed using the Revenue Code 551, per unit of service. One (1) unit of service represents the entire comprehensive assessment process.

B. Reassessment Service

The HCB reassessment service:

1. Shall be performed at least every twelve (12) months or more often, if indicated by a change in the member's condition;

2. Shall determine the continuing need for HCB waiver services;

3. Shall be conducted using the same procedures as for an assessment service:

4. Shall be initiated by an HCB waiver provider who shall:

   (a) Notify the department no more than three (3) weeks prior to the expiration of the current level of care certification;

   (b) Assume responsibility to inform the PRO of the current through date at the time of the telephone call to ensure that the new certification period is consecutive;

   (c) Submit the reassessment information to the PRO within twenty-one (21) calendar days of the verbal level of care certification. If all criteria are met, the PRO shall evaluate the reassessment material and authorize continued coverage for the HCB Waiver services. The PRO will not issue a retroactive prior authorization of services for packets not received within the set timeframes; and

   (d) Not be reimbursed for a service provided during a period that an HCB member is not covered by a valid level of care certification.

5. Shall not be retroactive. Meaning any member for whom recertification has not been requested by the end date of the current certification period shall experience a period of ineligibility for waiver services.

6. May be effective on the date of the telephone call to the PRO, if no more than sixty (60) calendar days have elapsed

since the end of the previous certification period and other recertification criteria are met.

If more than sixty (60) calendar days have elapsed since the end of the previous certification period, the member shall be considered to be terminated from the HCB Waiver program. In order for the member to be readmitted to the HCB Waiver program the HCB Waiver Provider shall follow the steps for an initial admission.

C. Case Management

1. Definition of Case Management

Case Management shall be a system under which a designated qualified individual is responsible for location, coordination and monitoring a group of services.

Effective case management is the management and coordination of the delivery of all services to the HCB Waiver member. These services include direct HCB Waiver member services provided by the HCB Waiver Provider as well as all other services included in the member's plan of care, transportation, volunteer services, informal support services, physician or clinic visits. It may also include arranging for drugs, supplies or related medical equipment.

A quality case management system eliminates fragmentation and duplication of patient services; ensures the continuity of necessary services; monitors all aspects of patient care; observes changes in condition or unmet needs; ensures the most appropriate and cost-effective patient care; facilitates a close and positive relationship with the HCB Waiver member; and, affords the member and legal representative the security that a qualified individual understands their needs and will assist them as needed. The HCB Waiver Provider shall designate a case manager.

2. Care planning resulting in the development of a plan of care that shall:

(a) Reflect the needs of the HCB Waiver member;

(b) List goals, interventions and outcomes as related to the HCB Waiver member's identified needs;

(c) Be in place prior to the provision of services;

(d) Specify the services needed by the member;

(e) Determine the amount, frequency, and duration of services;

(f) Contain provisions for reassessment at least every twelve (12) months;

(g) Have input from other persons which may include other professionals and home health aides;

(h) Be reviewed and signed by the attending physician, PA, or ARNP; and

(i) Be submitted to the department within fourteen (14) calendar days of receiving the department's verbal approval of nursing facility level of care. The PRO will not issue a retroactive prior authorization of services for packets not received within the set timeframes.

2. Case Manager Qualifications and Responsibilities

The case manager shall be an RN, LPN, a qualified social worker, certified psychologist with autonomous functioning, licensed psychological practitioner, licensed marriage and family therapist or a licensed professional clinical counselor. Case managers shall have intensive knowledge of the member, family and the community.

The case manager shall be responsible for locating the needed available resources. These resources may be formal health and social agencies or informal family and community supports. The case manager has the responsibility to:

(a) Bring the HCB Waiver member's needs to the attention of the appropriate referral source and to the appropriate staff within the HCB Waiver Provider agency;

(b) Coordinate, manage and monitor the delivery of services to the HCB Waiver member including working with the family and other informal caregivers;

(c) Have regular contact with each HCB Waiver member either by telephone or by home visits (all contacts shall be documented in the member's record);

(d) Link HCB Waiver members with informal community services (e.g., neighborhood helping networks, churches, schools, civic organizations, volunteers, etc.) to maximize the use of community resources;

(e) Promote family involvement in meeting the health care needs of the HCB Waiver member;

(f) Consult as needed with others involved in the provision of services;

(g) Actively participate in the assessment and reassessment processes; and

(h) Seek alternative arrangements as the HCB Waiver member's needs dictate.

A case manager shall be designated in each HCB Waiver member's clinical record.

Each HCB Waiver member shall have at least one (1) case management contact per month to assess the service delivery. The contact may be made by telephone or face-to-face. However, a face-to-face contact with the HCB Waiver member shall be made at least every other month. The face-to-face contact with the HCB Waiver member may be made while the member is at the Adult Day Health Care Center (ADHC).

Case management shall be face-to-face or telephone contact with the member or with resources. Group conferences shall **not** be billable as case management services.

The case management shall be documented in the medical record to include the reason for the case management service and a reflection of its impact upon the HCB Waiver member's plan of care. There shall also be documentation of the service provided and the actual time for each billable service.

3. Reimbursement for Case Management Service

Case management shall be billed using Revenue Code 590 per unit of service. One (1) unit of service is equal to fifteen (15) minutes.

An **initial** unit of service that is less than fifteen (15) minutes may be billed as one (1) unit. After the initial unit, any service time less than fifteen (15) minutes shall be rounded down.

D. Homemaker Service

1. Definition of Homemaker Service

Homemaker service is defined as a service which shall consist of general household activities such as meal preparation and routine household care. This service shall be provided by a trained homemaker.

This service shall be provided to an HCB Waiver member:

(a) Who is functionally unable and would normally perform age-appropriate homemaker tasks; and

(b) If the caregiver regularly responsible for homemaker activities is temporarily absent or functionally unable to manage the homemaking activities.

2. Homemaker Qualifications and Requirements

The homemaker shall:

(a) Be free of communicable disease;

(b) Demonstrate the ability to read, write, understand and carry out instructions, record messages, keep simple records, and interact with an HCB Waiver member when providing the service;

(c) Have emotional and mental maturity; and

(d) Be properly trained to perform the assigned service by an HCB Waiver Provider. It will be the responsibility of the HCB Agency to ensure adequate training of staff.

3. Supervision

Homemaker services shall be provided under the supervision of an RN who shall make periodic visits (at a minimum of every sixty (60) days) to assess the patient's

health condition and the quality of the service provided. The RN shall have conferences with the HCB Waiver Provider of service and review the plan of care as often as necessary. These visits shall not be directly reimbursable, but are considered part of administrative costs.

4. Record Keeping Requirements

The homemaker shall maintain adequate records for Medicaid billings and claim procedures, including the nurse's instructions and the actual time spent for each billable service. The provider's record shall include the documentation of RN's fulfillment of the supervision requirements.

5. Reimbursement for the Homemaker Service

The homemaker service shall be billed using the Revenue Code 582. One (1) unit is equal to thirty (30) minutes of service (excluding travel time).

An **initial** unit of service that is less than thirty (30) minutes may be billed as one (1) unit. Beyond the initial unit, service time less than fifteen (15) minutes shall be rounded down; service time that is equal to or greater than fifteen (15) minutes shall be rounded up.

NOTE: Shopping for groceries and picking up medications shall not be considered covered services unless provided in conjunction with a visit to provide a covered service.

NOTE: Personal care service and homemaker service may be provided on the same day by the same person. Member records shall appropriately identify the service provided and time involved with each service.

LIMITATIONS: Homemaker services are limited to four (4) units per week.

E. Personal Care Services

1. Definition of Personal Care Services

Personal care services shall be medically-oriented services relating to the HCB Waiver member's physical requirements as opposed to housekeeping requirements. Personal care services shall be prescribed only in cases where the HCB Waiver member does not need highly skilled or technical care.

Personal care services shall be furnished to an HCB Waiver member in their home according to the plan of care. These services shall be provided by an individual who is qualified, supervised by an RN, and not a member of the member's family.

Personal care services vary depending on the needs and requirements of each HCB Waiver member. Personal care services may include the following:

(a) Basic personal care and grooming, including bathing, care of the hair, and assistance with clothing;

(b) Assistance with bladder or bowel requirements or problems, including helping the member to and from the bathroom or assisting the member with bed pan routine;

(c) Assistance with ambulation and transfer; and

(d) Assisting the member with medications which are ordinarily self-administered, when ordered by the member's physician.

2. Personal Care Qualifications and Requirements

The personal care aide shall:

(a) Be free of communicable disease;

(b) Demonstrate the ability to read, write, understand and carry out instructions, record messages, keep simple records, and interact with the HCB Waiver member when providing the service.

(c) Have the emotional and mental maturity and interest in and attitude toward providing personal care services to elderly and disabled individuals in the home setting; and

(d) Be properly trained by the HCB Waiver Provider.

3. Supervision

The RN shall make periodic visits (at a minimum of every sixty (60) days) to assess the HCB member's health condition and the quality of the service provided. These visits shall not be directly reimbursable, but may be considered part of administrative cost. The RN shall have conferences with the staff providing personal care and review the plan of care as often as necessary.

4. Record Keeping Requirements

Adequate records of provision of personal care services shall be maintained for Medicaid billings and claim procedures, including the RN's instructions and documentation of the actual time spent for each billable service. These records shall include the documentation of the RN's fulfillment of the supervision and monitoring requirement.

5. Reimbursement for Personal Care Services

The personal care service shall be billed using the Revenue Code 581. One (1) unit is equal to thirty (30) minutes of service (excluding travel time).

An **initial** unit of less than thirty (30) minutes may be billed as one (1) unit. Beyond the initial unit, service time less than fifteen (15) minutes shall be rounded down; service time that is equal to or greater than fifteen (15) minutes shall be rounded up.

NOTE: Personal care services and homemaker services may be provided on the same day by the same person. However, they shall be billed on separate lines of the UB-92.

F. Respite Care Service

1. Definition of Respite

Respite shall be defined as short term care which is provided to an HCB Waiver member due to the absence or need for relief of the primary caregiver. The need for relief may be caused by a hospital stay of the caregiver, other family problems affecting the caregiver, vacation for the caregiver or a need for relief of the caregiver on a more regular basis (such as every two (2) weeks).

Respite care service may be provided in the HCB Waiver member's place of residence, which may be his own home or the home where he is staying at the time the service is provided. The HCB Waiver Provider shall be responsible for the arrangement and monitoring of the respite care services. The HCB Waiver Provider shall be responsible for ensuring that the respite care is provided at a level to appropriately and safely meet the medical needs of the HCB Waiver member and that the caregiver has the appropriate training and qualifications. This may require that the respite care provider be a licensed nurse (RN or LPN). Respite provided to children shall be required to be of a skill level beyond

normal baby-sitting. The HCB Waiver Provider shall also be responsible for ensuring adequate supervision of the respite care providers. The respite care provider shall not be a member of the HCB Waiver member's family.

Respite care services may also be provided by the ADHC. In this instance it shall be the responsibility of the ADHC to assure that the respite care is at a level to appropriately and safely meet the medical needs of the HCB Waiver member.

2. Respite Qualifications and Requirements

The respite care provider shall:

(a) Be free of communicable disease;

(b) Demonstrate the ability to read and write, understand and carry out instructions, record messages, keep simple records, and interact with the HCB Waiver member when providing the service;

(c) Be emotionally and mentally mature; and

(d) Be interested in providing respite care services to elderly or disabled individuals in the home setting or ADHC.

3. Record Keeping Requirements

The HCB Waiver Provider shall maintain adequate records of the respite care services for Medicaid claims and billing procedures as well as documentation of the service provision and the actual time spent for each billable service.

4. Reimbursement for Respite Service

The respite service shall be billed using the Revenue Code 660. One (1) unit is equal to one (1) hour.

An **initial** unit of less than one (1) hour shall be billed as one (1) unit. Beyond the initial unit, the service shall be billed according to the actual amount of time the service is provided. For example:

One (1) unit = one (1) hour to one (1) hour, fifty-nine (59) minutes.
Two (2) units = two (2) hours to two (2) hours, fifty-nine (59) minutes.

LIMITATIONS: Limitations shall be determined by individual member regardless of whether the provider is the HCB Waiver Provider or the ADHC. Reimbursement for respite care services shall be limited to no more than $2,000 per HCB Waiver member per six (6) month period, (January 1 to June 30 and July 1 to December 31), not to exceed $4,000 per HCB Waiver member per calendar year.

G. Minor Home Adaptations

1. Definition of Minor Home Adaptations

Minor home adaptations shall be changes or additions made to the HCB Waiver member's living environment to make it possible to remain in the current living arrangement. The adaptations shall relate strictly to the HCB Waiver member's disability and needs. The adaptations shall be necessary for the HCB Waiver member to function in the current living arrangement. These adaptations do not have utility for a person without such disability and do not constitute ineligible room and board or general housing maintenance. Major repairs shall not be considered adaptations and shall not be covered.

HCB Waiver services shall not be provided to an individual who does not require a service other than a minor home adaptation, case management or a minor home adaptation and case management.

Minor home adaptations may include but not be limited to: bath tub rails, commode railings, grab bars, commode extenders, step railings, bathtub set, and ramps, etc. This service shall include costs relating to labor and necessary supplies for the adaptation. Through the provision of minor home modifications, injury may be avoided that would further incapacitate the HCB Waiver member who already has care needs within the scope of NF benefits. Furthermore, these adaptation may mean the difference between remaining in the community and being admitted to a Nursing Facility.

2. Minor Home Adaptation Requirements

Minor home adaptations shall be arranged by the participating HCB Waiver Provider. The adaptations shall be safe and adequate to meet the HCB Waiver member's needs. The HCB Waiver Provider shall ensure that these requirements are met.

The provision of minor home adaptations shall be in compliance with all applicable state and local laws including any building code requirements and the hiring of licensed contractors where applicable.

3. Record Keeping Requirements

The HCB Waiver Provider shall maintain adequate records of the minor home adaptations for Medicaid claims and billing procedures.

4. Special Procedures Related to Minor Home Adaptations

A MAP-95 shall be completed for each minor home adaptation and be submitted with the assessment documentation.

5. Reimbursement for Minor Home Adaptations

Minor home adaptations shall be billed using the Revenue Code 290. One (1) unit is equal to one (1) item.

Limitations: Reimbursement for minor home adaptations shall be limited to a maximum of $500 per HCB Waiver member, per calendar year.

H. Attendant Care Services

1. Definition of Attendant Care Service

Attendant care service shall be defined as hands-on care, both of a medically oriented (appropriate to the skill level of the attendant care provider) and non-medically oriented nature specific to meet the needs of an HCB Waiver member who:

(a) Is medically stable but very functionally dependent;

(b) Requires care or supervision twenty-four (24) hours per day; and

(c) Has family or other support providing care but who are employed outside the home and are unable to provide care during working hours. The family or friend providing care shall not be required to live in the same residence as the HCB Waiver member for whom they are providing care. However, the family or friend shall provide care or supervision in the HCB Waiver member's home during the hours the attendant care provider is unavailable; and

(d) Provided self-care prior to meeting HCB Waiver eligibility requirements.

"Medically oriented" relates to the HCB Waiver member's physical needs requirements as opposed to the individual's housekeeping needs.

"Non-medically oriented" relates to activities which are necessary to the performance of environment specific housekeeping needs.

Approval shall not be given for personal care, homemaker or ADHC services when attendant care has been authorized.

The plan of care shall identify the need for attendant care services and determine the amount of time required to meet the HCB Waiver member's needs utilizing all other existing services and resources available to the HCB Waiver member. A service plan shall be developed to identify the tasks provided during the time the attendant care provider is there. The HCB Waiver member and family shall be involved in plan development. Supervision shall be provided by an RN. The frequency and intensity of the supervision shall be specified in the written plan for attendant care service, but at least as often as every sixty (60) days.

2. Attendant Care Service Requirements

The attendant care provider shall:

(a) Be free of communicable diseases;

(b) Demonstrate the ability to read and write, understand and carry out instructions, record messages, keep simple records, and interact with the HCB Waiver member when providing the service;

(c) Have the emotional and mental maturity and interest in providing attendant care services to elderly and disabled individuals in the home setting;

(d) Not be a member of the HCB Waiver member's family; and

(e) Be properly trained by the HCB Waiver Provider.

3. Supervision

The RN shall make periodic visits (at a minimum of every sixty (60) days) to assess the HCB Waiver member's health condition and the quality of the services provided. These visits shall not be directly reimbursable, and are considered as part of the rate for the attendant care. The RN shall have conferences with the staff providing attendant care and review the plan of care as often as necessary.

4. Record Keeping Requirement

Adequate records of provision of attendant care services shall be maintained for Medicaid billings and claim processing, including documentation of the actual time spent for each billable service. These records shall include the documentation of the RN's fulfillment of the supervision and monitoring requirements.

5. Reimbursement for Attendant Care Services

The attendant care service shall be billed using the Revenue Code 580. One (1) unit is equal to sixty (60) minutes of service (excluding travel time).

LIMITATIONS: Reimbursement for attendant care services shall be limited to forty-five (45) hours per week.

SECTION V – HOME AND COMMUNITY BASED WAIVER PROGRAM COVERED SERVICES

I. Adult Day Health Care Services

For information regarding ADHC services, please refer to the "Department for Medicaid Services, Adult Day Health Care Services Manual", Transmittal #1, May 2005 edition.

SECTION VI

ADDITIONAL FORMS